Danell Will, LPC
1 West Sunbridge Drive
Fayetteville, AR 72703
(479)443-5575 (479)443-9554

CONFIDENTIAL PATIENT INFORMATION

Date: ______________

Last Name: ______________________ First Name: ______________________ Date of Birth: _____________

Address: ____________________________________ City/State: _________________________ Zip: ________

Phone (C): ____________________ (W): _________________________ (H): _________________________

Social Security #: _________________________________ Marital Status: _______________________________

Occupation: _______________________________ Place of Employment: ______________________________

May we contact you at work? Yes No May we leave messages for you at work? Yes No

Spouse's Name: ____________________________ Spouse's Education/Occupation: _____________________

Referred by: ____

With whom, if anyone, do you live? (Relationship & names) ____

Have you ever been hospitalized? Yes No

If yes, please describe: ____

Are you currently under a doctor's care for any medical problems? Yes No

If yes, please describe: ____

Are you currently taking any medication? Yes No

If yes, please name of medication/dosage: ____

Have you had any previous psychological treatment? Yes No

If yes, please describe: ____

Has anyone in your family been treated for a psychological problem? Yes No

If yes, please describe: ____

Do you drink alcoholic beverages? Yes No

If yes, how much do you drink weekly? ____

Have you ever had a drug problem? Yes No

If yes, please describe: ____

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Reason for visit: ____

____

____

____

Is there anything else you feel is important for me to know? _____________________________

____

____

____

Please check any of the following changes that apply to you.

______ Sleep
______ Appetite
______ Energy level
______ Concentration
______ Memory
______ Sadness
______ Irritability
______ Lack of enjoyment in usual activities
______ Hopelessness
______ Guilt
______ Elation
______ Increased talking

_______ Racing heart
_______ Difficulty breathing
_______ Sweats/chills
_______ Numbness/tingling in fingers or lips
_______ Lightheadedness
_______ Fears of dying or going crazy
_______ Chest discomfort
_______ Excessive worry
_______ Compulsive behavior
_______ Racing thoughts
_______ Poor judgment

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INFORMED CONSENT TO TREAT

I understand there are risks, varying lengths and methods of treatment, as well as possible consequences of the decided treatment which typically includes, some, or many of the following methods and interventions:

- Stabilization
- Decrease and relieve symptomatology
- Improve coping
- Skill development
- Grief resolution
- Stress management
- Behavior modification
- Medication management

1. While I expect benefits from this treatment I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.
2. I understand that this mental health provider does not provide emergency service and I will be informed of whom/where to call in an emergency or during the evening or weekend hours.
3. I understand that regular attendance will produce the maximum possible benefits but that I am free to discontinue treatment at any time in accordance with office policies.
4. I understand that I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance.
5. I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threat of harm to myself or another person.
6. I am not aware of any reason why I should not proceed with therapy/treatment and I agree to participate fully and voluntarily.
7. If applicable, I am the custodial parent of a minor child. I hereby give ____________________________, the non-custodial parent, permission to seek treatment on our child's behalf.

The provider practices with an association of independently practicing professionals which share certain expenses and administrative functions under the name PCA Resources, Inc. While they share office space, this provider is a completely independent professional rendering clinical services and is fully responsible for those services. Clinical records are separately maintained and other professionals cannot have access to them without your specific written permission.

If you have any questions regarding this policy, please discuss these with the provider as soon as possible. Your signature below indicates consent for psychological/psychiatric treatment and indicates that you have read the above statement and agree to the above terms. Your commitment to this process and your assistance in understanding these necessary policies are an important part of your care.

______________________________	______________________	________________
Patient Name	Patient Date of Birth	Witness

______________________________	______________________
Patient / Custodial Parent / Guardian Signature	Date

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LIMITS OF PATIENT CONFIDENTIALITY

Mental Health Providers have a legal obligation or duty to maintain the confidentiality of their communications with their patients. There are exceptions, however, to this right of confidentiality. These include the following:

- You are a danger to yourself or others.
- Child abuse is disclosed.
- Elder abuse is disclosed.
- You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
- Your therapist was appointed by the courts to evaluate you.
- Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
- Your contact is for the purpose of establishing your competence.
- Your contact is one in which your therapist must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
- You are under the age of 16 years and are the victim of a crime.
- You are a minor and your therapist reasonably suspects you are the victim of child abuse.
- You are a person over the age of 65 and your therapist believes you are the victim of physical abuse.
- If you are deceased and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting interest in property.
- You file suit against your therapist for breach of duty or your therapist files suit against you.
- You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
- You waive your rights to privilege or give consent to limited disclosure by your therapist.
- Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with your therapist.

I am consenting to receiving outpatient mental health treatment and understand my legal right to confidence and the aforementioned exceptions.

______________________	______________________	______________________
Patient Name	Patient Date of Birth	Witness

______________________	______________________
Patient / Custodial Parent / Guardian Signature	Date

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AUTHORIZATION TO CONTACT

Patient Name: ____ Patient Date of Birth: ____________

If applicable:
Custodial Parent / Guardian Name: ________________________ Phone: (______) _______ - _______

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time and that I may obtain a revised copy of the notice at the clinic location where I receive healthcare services.

Patient / Custodial Parent / Guardian Signature: ______________________________ Date: __________

If you are not the patient fill out the following information.

Name: ______________________________ Relationship to Patient: ______________________
Address: ____________________________ City/State: ______________________ Zip: __________
Phone: ______________________________

RELEASE OF INFORMATION FOR REFERRING PROVIDER

I authorize the provider to contact, or confirm with the referring provider, ______________________, an appointment made for follow-up as well as general information pertaining to psychological and emotional function if indicated. I understand detailed clinical information will not be released without my written consent.

DECLINE
NOT APPLICABLE

Patient / Custodial Parent / Guardian Signature: ______________________________ Date: __________

EMAIL AUTHORIZATION

By providing my email address below, I hereby agree to allow the provider to contact me by email regarding my child. I understand that my email will not be shared with any outside companies.

Email address: ____________________ @ ____________________________ DECLINE

Patient / Custodial Parent / Guardian Signature: ______________________________ Date: __________

RELEASE OF SCHOOL EXCUSE

I authorize the provider to send a school excuse to my child's school.

DECLINE
NOT APPLICABLE

Name of School: ______________________________ City/State: ______________________
School Phone: ______________________________ School Fax: ______________________
Patient / Custodial Parent / Guardian Signature: ______________________________ Date: __________

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PATIENT INFORMATION

Last Name: ______________ First Name: ______________ MI: ______
Address: ______________ City/State: ______________ Zip: ______
Phone (C): ______________ Phone (W): ______________ Phone (H): ______________
May we leave a msg? Yes No May we leave a msg? Yes No May we leave a msg? Yes No
Date of Birth: ______________ SSN: ______________ Marital Status: ______________
Gender: Female Male Employer: ______________ Referred by: ______________

SPOUSE INFORMATION <u>or</u> CUSTODIAL PARENT/GUARDIAN INFORMATION (if the patient is a minor)

Name: ______________ Date of Birth: ______________ SSN: ______________
Relationship: ______________ Phone: ______________

ADDITIONAL CUSTODIAL PARENT/GUARDIAN INFORMATION

Name: ______________ Date of Birth: ______________ SSN: ______________
Relationship: ______________ Phone: ______________

EMERGENCY CONTACT INFORMATION (if different than Spouse/ Custodial Parent/Guardian)

Name: ______________ Relationship: ______________ Phone: ______________

PRIMARY INSURANCE INFORMATION

NO INSURANCE / PRIVATE PAY

Patient's relationship to Policy Holder: Self Spouse Child Step-Child Other
Insurance Company: ______________ Insurance Phone: ______________
Policy Holder's Name: ______________ SSN: ______________ Date of Birth: ______________
Policy Holder's Address: ______________ City/State: ______________ Zip: ______
ID / Policy#: ______________ Group/Plan/Division #: ______________
Employer: ______________

SECONDARY INSURANCE INFORMATION

NO SECONDARY INSURANCE

Patient's relationship to Policy Holder: Self Spouse Child Step-Child Other
Insurance Company: ______________ Insurance Phone: ______________
Policy Holder's Name: ______________ SSN: ______________ Date of Birth: ______________
Policy Holder's Address: ______________ City/State: ______________ Zip: ______
ID / Policy#: ______________ Group / Plan / Division#: ______________
Employer: ______________

AUTHORIZATION FOR INSURANCE PAYMENT

My signature below indicates that I agree to authorize payment of insurance benefits to the service provider, authorize the release of any information necessary to process insurance claims, and accept payment responsibility of the portion of the bill which insurance does not cover.

Patient / Custodial Parent / Guardian Signature: ______________________ Date: ______________

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PERSON RESPONSIBLE FOR PAYMENT

Patient Parent listed above Other (complete the fields below)

Name: ______________ Relationship: ______________ Date of Birth: ________

SSN: ______________ Phone: ______________

Address: ______________ City & State: ______________ Zip: ________

RELEASE TO DISCUSS FINANCIAL INFORMATION

We cannot share information about your financial account with anyone unless we have your written authorization. The exceptions to this are biological parents of a minor child, those listed as legal guardians of adults, or anyone listed below.

I hereby authorize the provider and/or staff to disclose financial information with the following person(s):

DECLINE

Name: ______________	Name: ______________
Address: ______________	Address: ______________
______________	______________
Phone: ______________	Phone: ______________
Relationship: ______________	Relationship: ______________
Name: ______________	Name: ______________
Address: ______________	Address: ______________
______________	______________
Phone: ______________	Phone: ______________
Relationship: ______________	Relationship: ______________

Patient / Custodial Parent / Guardian Signature: ______________ Date: ________

PCA Resources, Inc.
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PERMISSION FOR CREDIT CARD ON FILE

Complete the information below if you would like to keep your debit card, credit card, health savings card, or flexible savings card on file for your portion of each visit.

DECLINE

Patient Name: ______________________________ SSN: ________________ Date of Birth: ____________

Cardholder Name: ____

Cardholder Address: ____

____

Card #: ________ - _________ - __________ - _________ Exp Date: ______ / _______

Visa MasterCard Discover AMEX CVV #: ____________

My signature below indicates that, as the cardholder, I agree to authorize payment for services rendered by the service provider. By signing I agree to accept total responsibility of the bill, in which total amounts may reflect 1. The full amount owed for service, 2. Copayment of insurance benefits, or 3. Other payment arrangements agreed upon by the patient, cardholder, and/or service provider.

Cardholder Signature: ____ Date: ______________

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PATIENT RESPONSIBILITY

I, ________________________, understand that I have contracted for services with the provider and that I alone am responsible for paying the amount that is billed for services. In particular,

1. I understand that PCA Resources, Inc. provides insurance filing as a courtesy and a convenience to me and/or will seek authorizations from my health care provider; however, these activities do not guarantee that my insurer will pay. I understand that at any time I am free to file my own insurance, in which case full payment of fees will be required at the time of service.
2. I understand that the business office will attempt to help me understand my insurance or managed care benefits and procedures, but that denial of benefits by my insurer means that I am fully responsible for the contracted amount.
3. I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for:
    - Obtaining the initial referral to the provider, if needed.
    - Ensuring I have pre-certification of visits, if needed.
    - Knowing limits regarding my deductible.
    - Keeping track of benefit limits. Keeping track of my benefits entails knowing any limits on my policy and ensuring that I do not exceed those limits (e.g., some insurers set a maximum of 20 mental health sessions per year). If I exceed my limits and my insurer refuses to pay, I will be responsible for the amount refused. Also, I understand that if I am seeing another social worker, psychologist or psychiatrist, those sessions may count against my mental health benefits. I also realize that while my managed care provider may authorize visits as appropriate for me, that does not mean that they will necessarily pay for those visits (e.g., Some insurers will authorize 35 visits when they will only pay for 30 visits).
4. A fee of $150.00 per scheduled hour will be charged if I do not give a **24** hour notice (during normal business hours) to cancel an appointment, with the exception of mutually agreed upon **emergencies**. Insurance cannot be billed for this fee, as they will not pay for missed appointments.
5. A fee of $37.50 will be charged to my account for every 15 minutes I am late for a scheduled appointment. In addition, any other work, such as phone calls, letter writing, case management, etc. that take more than 15 minutes will be billed in 15 minute increments at $37.50 each. Insurance cannot be billed for either of these fees.
6. I understand that if my policy changes or if I switch insurance companies, I should inform the office immediately. If the office does not have the proper information and cannot collect payment from the insurer, I am responsible for the amount the insurance company will not pay.
7. I also understand that in the instance of my account getting turned over to collections that I am responsible for the entire bill plus 100% of collection fees.

______________________________	____________________	______________
Patient Name	Patient Date of Birth	Witness

______________________________	____________________
Patient / Custodial Parent / Guardian Signature	Date

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PATIENT RESPONSIBILITY FOR LITIGATION

I, ________________________________, understand that I have contracted for psychiatric services with the provider and that I alone am responsible for paying the amount that is billed for services. In particular,

1. Due to complexity and difficulty of legal involvement, the provider charges $300.00 per hour for preparation and attendance at any legal proceedings.
2. Court appearances are charged in 4 hour increments (e.g. 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm, at $1,200.00 per half day). These charges apply regardless of whether testimony is given.
3. Payment will be required in full by 5:00 pm 3 business days prior to the scheduled court proceedings. In the event that the case is settled or less time is required, the excess amount paid will be promptly refunded.
4. We cannot bill your insurance company for any charges related to litigation.
5. If a third party, such as your attorney, is responsible for the fees incurred it is your responsibility to ensure payment. If the third party, even if contractually obligated to pay, does not pay, I ________________________________ will be responsible for the full balance plus any additional fees incurred if the account is referred to an attorney for collection.
   a. If a third party is responsible for payment, the obligations must be in writing, signed, and preserved.
   b. Payment will be required in full by 5:00 pm 3 business days prior to the scheduled court proceedings.
6. Court ordered evaluations are only accepted with advanced retainer of $5,000.00 plus, for psychologists, advance payment for the cost of the evaluation ($300.00 per face-to-face hour at approximately 12-14 hours total).

______________________________________ ________________________ __________________
Patient Name Patient Date of Birth Witness

______________________________________ ________________________
Patient / Custodial Parent / Guardian Signature Date

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DIRECTIONS TO PSYCHOLOGY & COUNSELING ASSOCIATES

Coming from I-49 North/South

- Exit at Fayetteville Business District
- Take the Gregg Street Exit
- Turn RIGHT on Futrall/Milsap
- Turn LEFT on Gregg Street
- Turn LEFT on Sunbridge Drive
- Approximately 3 blocks down on the RIGHT side. Just past the Breast Center. On the corner of Sunbridge Drive and New School Place

Coming from Springdale/North Fayetteville/NW Arkansas Mall

- Going South on College Ave (US 71 BR), turn RIGHT on Sunbridge Drive (stop light after Fiesta Square, before Township)
- 1st parking lot on the left after you pass New school Place

Coming from South Fayetteville/University of Arkansas

- Going North on College Ave (US 71 BR) towards Springdale, turn LEFT on Sunbridge Dr (stop light after Township, before Fiesta Square)
- SUNBRIDGE DRIVE IS 1 BLOCK NORTH OF TOWNSHIP
- 1st parking lot on the left after you pass New school Place